PRINTED: 03/13/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER ANDBE HOME, INC SUMMARY STATEMENT OF DEPICIONCES PREFIX AND OF CORRECTION OF DEPICIONCES PREFIX TAG CACH DEFICIENCY AUST OF DEPICIONCES TAG CACH DEFICIENCY AUST OF DEPICIONCES TAG CACH DEFICIENCY AUST OF DEPICIONCES PREFIX TAG CACH DEFICIENCY AUST OF DEPICIONCES TAG CACH DEFICIENCY AUST OF DEPICIONCES TAG CACH DEFICIENCY AUST OF DEPICIONCES TAG CACH DEFICIENCY AUST OF DEPICE AUST OF DEP	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
ANDRE HOME, INC ANDRE HOME, INC SUMMARY STATEMENT OF DEFICIENCIES OF PREED TO THE APPROPRIATE OF DEFICIENCIES OF THE PREED THAT OF DEFICIENCIES OF THE PREED THAT OF DEFICIENCIES OF THE PREED THAT OF DEFICIENCY AUST BE PREEDED BY FULL REQUILATORY OR I.SC.IDENTIFYING INFORMATION). FOOD INITIAL COMMENTS Food INITIAL COMMENTS Food The following citations represent the findings of the compilaint survey into compilaint #64051. A revised 2567 was sent to the facility by e-mail on 3/13/13. F157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's hybrician; and if known, notify the resident which results in injury and has the potential for requiring physician intervention: a significant change in the resident's physician complications), a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment), or a decision to transfer or discharge the resident significantly (i.e., a need to discontinue an existing form of treatment), or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's			175506	B. WING			l	
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the address and phone number of the resident's		and, if known, the res or interested family m change in room or roo specified in §483.15(resident rights under regulations as specific	ident's legal representative lember when there is a ommate assignment as le)(2); or a change in Federal or State law or					
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		the address and phor	ne number of the resident's					(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		175506	B. WING				C 12/2013
NAME OF PE	ROVIDER OR SUPPLIER			201	T ADDRESS, CITY, STATE, ZIP CODE W CRANE ST RTON, KS 67654	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 157	This REQUIREMEN' by: The facility census to residents included in residents were review after change in conductor record review the fact resident's physician a significant change status. Findings included: Review of resident nurse's note entry dattented the resident's responsed to up administered a Duor to consult with a phy in the resident's responsed for the nurses of breath at thick yellow sputum. Sounds to the left and wheezing noted on experience oxygen saturation was he/she ambulated. The Duoneb treatment arroxygen per nasal call	or interested family member. T is not met as evidenced otaled 70 residents with 7 the sample. Of those, 3 wed for nursing assessment ition. Based on interview and cility failed to consult with the immediately after identifying in resident #1's respiratory It #1's record revealed a ated 12/12/12 at 9:00 p.m. In mented a temperature of 99.5 ident was confused, staff dent's lungs sounds had oper lobes. The staff neb treatment The staff failed sician regarding the change oiratory status. Is notes dated 12/12/12 at It the resident complained of and a productive cough with The resident had diminished d right lower lobes with expirations. The resident's as 79% on room air after the staff administered a and placed the resident on nnula. The staff failed to cian regarding the change in	F	157			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		175506	B. WING _			C / 12/2013
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 W CRANE ST NORTON, KS 67654		
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F 157	2:00 a.m. revealed staphysician regarding the congestion, wheezing Staff failed to call and regarding the residen. Further review of the entry on 12/13/12 at had a temperature of 100 degrees is abnornable sounds, oxygen saturoxygen per nasal can pressure 175/103 (abhigh), and the resident staff called the physic send the resident to the chest x-ray. The residents are presented to the chest x-ray. The residents are presented to the physic send the resident to the chest x-ray. The residents are prevented to the physic send the resident to the chest x-ray and the wheezing went away have any new change reported to the physic revealed the residents and the wheezing cleatreatment. Nurse D recondition. Nurse D recondition to have wheat the condition to have whe status. She revealed physician concerning	notes dated 12-13-12 at aff sent a fax to the ne resident cough, and low grade temperature. consult with a physician t's condition. Nurses Notes revealed an 6:00 a.m. The resident then 101.5 Fahrenheit (above mal) diminished lung ation 94% on 2 liter of nula, pulse 118, blood ove 140/80 is considered at coughed up blood. The cian and obtained an order to the emergency room for a dent was admitted to the fact. It 4:22 p.m. with Licensed to the resident's and he/she did not seem to the stan. Licensed nurse D is had period of confusion ared with a DuoNeb aerosol evealed the facility's reses was to notify the resident had a change in evealed he/she would have if the resident had eezing or altered mental the nursing staff faxed the non-emergency related	F 1			
	physician concerning					

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17	7 5506 B. WIN			03/	C 12/2013
NAME OF PROVIDER OR SUPPLIER ANDBE HOME, INC		201	ET ADDRESS, CITY, STATE, ZIP CODE W CRANE ST RTON, KS 67654	<u> </u>	12/2013
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING IN	ED BY FULL PRE	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
Interview on 3-6-13 at 4:40 p.m. interview on 3-6-13 at 4:40 p.m. interview of an antified him/her of the resident coughed up blood. Interview on 3-6-13 at 4:40 p.m. inter Administrative Nurse A revealed after reviewed the nurses notes for 12-12-12-13-12 the nurses should have page doctor and notified him/her of the residenge of condition instead of sending 2:00 a.m. and waiting to call the physical a.m. the resident coughed up blood. Interview on 3-7-13 at 9:55 a.m. with Administrative Nurse A revealed the not have a policy for notifying the physicange in the resident's condition. Nurevealed the facility's expectation inclinurses would notify the physician by page for anything that required a chatreatment such as difficulty breathing and symptoms of illness. Interview on 3-7-13 at 10:54 a.m. with Practitioner E revealed the expectation office was the facility would call or paif the resident had signs and symptom or significant change in condition for to address. Staff E revealed emergency concerns should not be faxed to the pafter office hours, faxes were for notifinon-emergency related concerns. The facility failed to identify immediat with the resident's physician after idesignificant change in the resident's restatus. F 309 483.25 PROVIDE CARE/SERVICES	is/her required a view with he/she 12 and ged the ident's ig a fax at ician until 6 facility did rsician with a urse A uded the phone, or nge in and signs n Nurse ons of his/her ge the office ns of illness the physician ncy related ohysician fication of ely consult ntifying a spiratory	= 157			

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		175506	B. WING			C 03/12/2013		
NAME OF PR	OVIDER OR SUPPLIER			20	EET ADDRESS, CITY, STATE, ZIP CODE 01 W CRANE ST ORTON, KS 67654	1 03/	12/2013	
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F 309 SS=G	Each resident must re provide the necessary or maintain the higher mental, and psychosol	NG eceive and the facility must y care and services to attain st practicable physical,	F	309				
	This REQUIREMENT is not met as evidenced by: The facility census totaled 70 residents with 7 residents included in the sample. Of those, 3 residents were reviewed for nursing assessment after change in condition. Based on interview and record review, the facility failed to identify and respond promptly to a significant change in respiratory status after a change in condition for 1 of 3 sampled residents. This failure lead to a delay in resident #1 receiving further respiratory care. The resident received increased breathing treatments, and oxygen began to cough up sputum and blood and required hospitalization. Findings included: - Review of resident's #1's physician's orders sheets signed and dated 2/1/12 revealed a diagnosis of Atrial Fibrillation (an abnormal and irregular heart rhythm). Review resident #1's admission MDS (minimum data set) dated 2/6/12 revealed the resident had a BIMS (brief interview for mental status) score of 14 (cognitively intact), required set up help with							

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NAME OF PE	ROVIDER OR SUPPLIER		•	201 W	ADDRESS, CITY, STATE, ZIP CODE CRANE ST CON, KS 67654	,	
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F 309	9/15/12 revealed a B intact) required set up dressing, one person extensive assist of or Review of the resider CAA (care area asse revealed the resident hearing aids in his/he resident was independent was i	1's quarterly MDS dated MS score of 15 (cognitively of help for meals and assist for dressing, and the staff member for bathing. 1's Activities of Daily Living assment) dated 2/6/12 was hard of hearing, wore in right ear and glasses. The indent with transfers and ed walker and staff was to a specific organ) metabolism alteration in quate blood pumped by the indirected the staff to give ing treatment) every 4 hours boughing/wheezing. 1's record revealed a nurse's 2/12 at 9:00 p.m. Which arature of 99.5 degrees identified the resident was enced wheezing lung sounds the staff administered a address the wheezing but temperature. 1 notes dated 12/12/12 at its after the last Duoneb mented the resident	F	309			

, ,		IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175506	B. WING			1	C 42/2042
NAME OF PE	ROVIDER OR SUPPLIER		1 - 1	ST	REET ADDRESS, CITY, STATE, ZIP CODE 201 W CRANE ST NORTON, KS 67654	1 03/	12/2013
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F 309	oxygen saturation lev 100%) on room air aff assessed the lung so change that included left and right lower lo expirations. The staff treatment and placed nasal cannula. The st other respiratory care Further review of the entry on 12/13/12 at assessed the residen 101.5 degrees Fahrer abnormal), oxygen sa oxygen per nasal can normal), blood pressuis considered high), a blood. The staff noted diminished lung sounfields. At that time, 9 started showing sympneed for breathing tre confusion, and product sputum, staff called the an order to send their room for a chest x-ray admitted to the hospit linterview on 3-6-13 at nurse D revealed the periods of confusion a cleared with a DuoNe D revealed he/she wiphysician if the reside	a thick yellow sputum, and sel of 79% (normal is 98 to be ser ambulation. Staff unds and identified a diminished sounds to the bes with wheezing noted on administered a Duoneb the resident on oxygen per aff failed to provide any. Nurses Notes revealed an 6:00 a.m. When staff the with a temperature of sheit (above 100 degrees is sturation 94% on 2 liter of shula, pulse 118 (60-100 are 175/103 (above 140/80 and the resident coughed up do the resident had do throughout the lung shours after the resident stoms and had increased atments, oxygen, exhibited ctive cough with yellow the physician and obtained the esident to the emergency of the resident was all for pneumonia. 14:22 p.m. with Licensed resident normally had and that night the wheezing be aerosol treatment. Nurse could have notified the ant had continued to have the nental status. The nurse	F	309			

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		175506	B. WING				C 1 12/2013
NAME OF PR	OME, INC	1	-	201	ET ADDRESS, CITY, STATE, ZIP CODE W CRANE ST PRTON, KS 67654	, 30.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325 SS=D	treatments, the need breath and productive significant respirator. Interview on 3-7-13 a Practitioner E reveal office was the facility if the resident had si or significant change to address. The facility failed to it significant change in status including increased for oxygen, she productive cough. The lead to the worsenin status and a hospita 483.25(i) MAINTAIN UNLESS UNAVOID. Based on a resident assessment, the fact resident - (1) Maintains accept status, such as body unless the resident's demonstrates that the	are, increased breathing If for oxygen, shortness of the cough all signs of ty change. at 10:54 a.m. with Nurse ted the expectations of his/her to would call or page the office tigns and symptoms of illness the in condition for the physician adentify and respond to a the resident's respiratory teased breathing treatments, to truess of breath and his delay in prompt treatment tig of the resident's respiratory tigation. NUTRITION STATUS ABLE The scomprehensive tility must ensure that a to weight and protein levels,		325			
	by:	T is not met as evidenced otaled 70 residents, with 7					

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		175506	B. WING			l	C
NAME OF PR	COVIDER OR SUPPLIER	173300	B. Wille	201	ET ADDRESS, CITY, STATE, ZIP CODE W CRANE ST RTON, KS 67654	03/	12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325	residents were sampl reviewed for nutrition. interview and record in provide nutritional supphysician for 1 of 3 refindings included: Review of the residence of 10 (moderately impextensive assist of two mobility, transfers, drepersonal hygiene. The extensive assist of on and setup help and simples in the mobility, transfers, drepersonal hygiene. The extensive assist of on and setup help and simples in the mobility in the mobility, transfers, drepersonal hygiene. The extensive assist of on and setup help and simples in the mobility in the mobility. The resident had no significated 9/10/12 revealed with a BIMS score of impairment. The resident had no significated 9/10/12 revealed with a BIMS score of impairment. The resident had requires medical antidepressant. Review of the resident dated 9/10/12 revealed mechanical soft diet, and recommendated soft diet.	ed of those 3 resident were Based on observation, review, the facility failed to oplements as ordered by the sidents. (#3) Itent's significant change set) dated 9/5/12 revealed of for mental status) score raired) the resident required of staff members for bed resident required resident required resident required resident had no broken or lose ras 64 inches and he/she The MDS revealed the ricant change in weight. It #3's cognitive rare area assessment) red resident was a new admit resident was a new admit resident had a diagnosis of recondition that effects mood reatment) and received an It's nutritional status CAA received Ensure (high k) for nutritional support,	F	325			

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NAME OF PR	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 01 W CRANE ST IORTON, KS 67654	1 00,	12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325	Review of resident #3 data set) dated 1/28/1 interview for mental s (moderately impaired of two staff members walking, dressing, and required extensive as bathing and personal required set up help f MDS revealed the resinches and he/she we MDS revealed the resisches and he/she we MDS revealed the resisches and he/she we may be set to be swallowing problems change. Review of the resident revealed the following maintenance and nuttiplan directed the staff regular diet with textuin the main dining roo choice, remind the redrink plenty of liquids resident's weight weed daily for nutritional sure Review of the physiciand dated 2/27/13 revealed the regular diet with ensure regular diet with ensurements.	It's quarterly MDS (minimum 13 revealed a BIMS (brief tatus) score of 9 (a), required extensive assist for bed mobility, transfers, and toileting. The resident sist of one staff member for hygiene. The resident rom staff for meals. The sident's height was 64 (a) sighed 132 pounds. The sident had no chewing or and had a significant weight was 64 (a) problem: alteration in fluid ritional status. The care of to provide the resident a re as tolerated, serve meals of mor room per his/her sident to eat slowly and to with food, monitor the kly, and give ensure liquid pplement. The sident was to receive a re 1 can BID. The sident had no chewing or and had a significant weight wealed an order for ensure 1 for nutritional supplement.	F	325			

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NAME OF PR	OVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 201 W CRANE ST NORTON, KS 67654	1 03/	12/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 325	10/02/12 136 pounds 11/02/12 132.5 pounds 12/04/12 126 pounds 01/11/12 127.5 pounds 02/01/12 133 pounds 02/26/12 129 pounds Observation on 3-5-13 direct care staff B too brand of high calorier tray that was labeled and served it to the re carton was a one serv 200 calories. The res mighty shake. Interview on 3-5-13 ar resident's family mem supply of ensure in th staff was supposed to and put in the refriger resident as ordered b Observation on 3-5-12 resident's supply of et his/her room revealed contained 350 calorie Interview on 3-5-13 ar staff B revealed the d a list of people that re supplements. The kito snack and supplemer with the residents nar unaware the resident of ensure bid between	as at 3:00 p.m. revealed k a Mighty Shake(another nutritional drink) off of the with the resident's name esident. The mighty shake ving container that contained ident drank 100% of the as at 3:14 p.m. interview with the ober revealed he/she kept a resident's room and the at take it out as it was needed ator and give it to the physician. 3 at 3:15 p.m. of the neure kept in a drawer in a sper can.	F	325			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		175506	B. WING				C 12/2013
NAME OF PR	OVIDER OR SUPPLIER			20	EET ADDRESS, CITY, STATE, ZIP CODE 01 W CRANE ST ORTON, KS 67654	1 03/	12/2013
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 325	Dietary staff C revealed might shake once dai resident had a physic bid. Staff C was unaw contained 350 caloried mighty shake only constaff C revealed that he resident's snack and suphysician's orders that for changes. Interview on 3-6-13 at Administrative staff A orders sheets signed an order for ensure 1 supplement. Staff A reprepared all the physicianed them with the direct care staff passed. The direct care staff passed The direct care staff or resident's that receives they were ordered to revised 7/27/05 reveal prepare and encourage as the doctor ordered and calories. The facility failed to page 250.	ed the resident received a ly. Staff C was unaware the ian's order for ensure 1 can vare that one can of ensure s, he/she confirmed the intained 200 calories. Dietary ne/she obtained the supplement orders from the supplement orders from the at he/she reviewed weekly 1 2:45 p.m. interview with confirmed the physician's and dated 2/27/13 revealed can BID for nutritional evealed that kitchen ician ordered snacks and resident's name and the ed them to the residents. Itid not have a list of all the ed snacks and what snacks get. 2 Nutritional policy last alled the facility was to ge nutritional supplements for extra added nutrition	F	325			